Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
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Bureau régional de services de Toronto
5700, rue Yonge 5e étage
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Téléphone: (416) 325-9660
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 29, 2021	2021_595110_0008	025265-20, 006678-21	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derrycrest Drive Mississauga ON L5W 0G5

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Gibson Long Term Care Residence
1925 Steeles Avenue East North York ON M2H 2H3

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 1-4, 7-8, 2021.

The following intakes were inspected during this Complaint Inspection:
Log #025265-20 related to failing to provide adequate fluids to residents.
Log #06678-21 related to an unexplained resident fall with injury and infection prevention and control.

The LTC home's infection prevention and control practices were also observed and inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Dietitian, Assistant Food Service Manager, Assistant Director of Care, Infection Prevention and Control Lead, Registered Nurse, Registered Practical Nurse, Dietary Aide, Personal Support Workers.

During the course of the inspection the Inspector toured resident home areas, conducted mealtime observations, reviewed clinical health records, daily line lists, surveillance lists, public health communications, active screening records and the home's hydration and infection prevention and control policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

A complaint was brought forward to the Ministry of Long-Term Care that residents were not being offered sufficient fluids throughout the day. PSW interviews conducted supported concerns that all residents were not offered the required amount of fluids each day according to the planned menu.

Resident #004 was observed over lunch and offered 125 milliliters (ml) of juice. The beverage standard to be offered, according to the planned menu, was 125ml water, 125ml milk and 125ml coffee or tea or the equivalent of 375mls of preferred fluids. These missing fluids represented a shortfall of 250mls being offered to resident #004 at lunch.

A review of the resident's total daily fluid intake, for the day observed, revealed a 325ml shortfall in fluids consumed based on their estimated fluid needs. [s. 71. (4)]

2. Resident #005 was offered 125ml of juice and not the planned menu at lunch. An amount of 250ml of fluids was not offered to resident #005.

A review of the resident's total daily fluid intake, for the day observed, revealed a 465ml shortfall in fluids consumed based on a range of their estimated fluid needs. [s. 71. (4)]

3. Resident #006 was observed and offered 125ml of juice and a mug of coffee or tea at lunch. A review of the dietary kardex and menu with a dietary aide confirmed that resident #006 should have received 125ml apple juice, 125ml milk, 125ml water plus coffee/tea. These missing fluids represented a shortfall of 250mls being offered to resident #006 at lunch.

A review of the resident's total daily fluid intake, for the day observed, revealed a 200ml - 465mls shortfall in fluids consumed based on a range of their estimated fluid needs. [s. 71. (4)]

4. Resident #011 was also monitored at lunch and offered 125ml of juice.

A review of the resident's plan of care directed staff to provide a preferred fluid at meals. The dietary aide confirmed that resident #011 should have received 125ml milk, 125ml water plus 125ml of their preferred fluid. These missing fluids represented a shortfall of

375mls being offered to resident #011 at lunch.

A review of the resident's total daily fluid intake, for the day observed, revealed a 875ml -1160mls shortfall in fluids consumed based on a range of their estimated fluid needs. [s. 71. (4)]

The planned menu for beverages/ fluids was not offered to residents #004, #005, #006, #011 and may have contributed to the residents not consuming their estimated fluid needs for the day.

Sources: 'Policy No: LTC-CA-WQ-300-05-08 Menu Fluid Guidelines', Resident #004, #005, #006 and #011's plan of care, mealtime observations, dietary kardex, staff interviews including PSWs #101, #105, #111, Dietary Aide #109, AFSM #106 and the RD. [s. 71. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #007's plan of care identified the need for an prescribed amount of fluids and a fluid plan. The plan included a specific amount of water at meals.

A mealtime observation identified the resident being served 125ml of juice and not water as required by the resident's fluid plan. The resident stated to the PSW they could not have the provided juice to which the PSW responded the resident's preferred juicer was not available. Another meal observation revealed the resident having been provided a large jug of water on their bedside table. An interview with the unit's RPN and RN revealed they were both unaware of the resident's fluid plan and prescribed fluids. An interview with the RD confirmed that a specified amount of water should have been offered at lunch and not juice and the resident should not have been provided with a jug of water.

Sources: observations, resident #007's plan of care, dietary kardex, interview with RPN #112, RN #113 and the RD. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Resident #005 was monitored at meals and observed to be offered less fluids than planned on the menu. Less fluids being offered to a resident than planned represented a risk to the resident's hydration status. An interview with the registered dietitian revealed the resident required a modified fluid consistency and feeding assistance, both further risk factors for dehydration.

A review of the resident’s plan of care failed to include the resident’s hydration status and their risks to hydration.

Sources: interview with RD, PCC Look Back Report -Fluids, plan of care, progress notes, observations and PSW interviews. [s. 26. (3) 14.]

Resident #011’s was monitored at meals and observed to be offered less fluids than planned on the menu. A review of the resident's health record identified episodes of poor fluid intake, and not meeting their estimated hydration needs.

A review of the resident’s plan of care failed to include the resident’s hydration status and

their risks to hydration including being provided less fluids at meals.

Sources: interview with RD, PCC Look Back Report -Fluids, plan of care, progress notes, observations and PSW interviews. [s. 26. (3) 14.]

2. The licensee has failed to ensure that the registered dietitian who was a member of the staff of the home assessed the resident's hydration status, and any risks related to hydration.

A mealtime observation was completed that identified a lack of fluids being provided to resident #005. Less fluids being offered to a resident than planned represented a risk to the resident's hydration status.

Resident #005 required assistance with feeding and a modified fluid consistency according to their plan of care.

A review of the RD's assessment failed to identify the resident was not meeting their estimated fluid needs, according to the fluid intake records. An Interview with the RD confirmed that resident #005 with reduced fluid intake; not receiving fluids as planned on the menu; requiring feeding assistance and a modified fluid consistency were all factors that placed the resident at risk for dehydration.

Resident #005’s hydration status and risks to hydration were not assessed by the RD. [s. 26. (4)]

4. A mealtime observation identified a lack of fluids being provided to resident #011. Less fluids being offered to a resident than planned represented a risk to the resident's hydration status.

A review of the RD's assessment failed to identify the resident was not meeting their estimated fluid needs, according to the fluid intake records. The homes' Hydration Tool placed the resident at Hydration risk related to episodes of poor fluid intake.

Resident #011’s hydration status and risks to hydration were not assessed by the RD.

Sources: Resident #005 and #011's care plan, Point Click Care Dietary Nutrition/Hydration Risk Assessment Tool, Look Back Report -Fluids, Dietary kardex, observations and interviews with PSW, dietary aide, Registered Dietitian. [s. 26. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the registered dietitian who is a member of the staff of the home assesses the resident's hydration status, and any risks related to hydration and the plan of care is based on the assessment of the resident's hydration status and any risks related to hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Resident #006's plan of care directed staff to provide feeding assistance to the resident and to feed slowly to reduce the risk for choking

A mealtime observation showed resident #006, positioned in bed, at a 45 degree angle with a tray table placed in front of them for self-feeding. No staff were present. The resident was observed looking at the meal tray and not eating. A request was made to the unit RN to confirm the resident's level of assistance at meals. The RN stated the resident could eat independently. After addressing the resident's position, the RN assisted the resident with their beverage and the resident began to drink with assistance.

Sources: Resident #006's plan of care, observations. [s. 73. (1) 9.]

2. The licensee has failed to ensure that proper techniques were used to assist a resident with eating, including safe positioning of residents who require assistance.

Resident #006's plan of care revealed the resident was at risk for choking and for staff to ensure the resident was sitting upright when eating.

A mealtime observation showed resident #006, positioned in bed, at a 45 degree angle with a tray table placed in front them for self feeding. A request was made to the unit RN to confirm the resident's position. The RN acknowledged the resident was positioned at 45 degrees, and stated it was not considered a safe position for eating and repositioned the resident.

Sources: Resident #006's plan of care, observations. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident was provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

Issued on this 14th day of July, 2021

[redacted]

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANE BROWN (110)
Inspection No. / No de l'inspection :	2021_595110_0008
Log No. / No de registre :	025265-20, 006678-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 29, 2021
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derrycrest Drive, Mississauga, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Gibson Long Term Care Residence 1925 Steeles Avenue East, North York, ON, M2H-2H3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Autumn Trumbull

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee must be compliant with s. 71.(4) of O. Reg. 79/10.

Specifically, the licensee must:

1. Provide residents with adequate fluids in accordance with the planned menu, unless otherwise indicated by the resident or by the resident's assessed needs.
2. Conduct twice-weekly audits on each resident home area, for a period of one month, following service of this order.
3. Retain copies of the audits for review by an Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that planned menu items were offered and available at each meal and snack.

A complaint was brought forward to the Ministry of Long-Term Care that residents were not being offered sufficient fluids throughout the day. PSW interviews conducted supported concerns that all residents were not offered the required amount of fluids each day according to the planned menu.

Resident #004 was observed over lunch and offered 125 milliliters (ml) of juice. The beverage standard to be offered, according to the planned menu, was 125ml water, 125ml milk and 125ml coffee or tea or the equivalent of 375mls of preferred fluids. These missing fluids represented a shortfall of 250mls being offered to resident #004 at lunch.

A review of the resident's total daily fluid intake, for the day observed, revealed a 325ml shortfall in fluids consumed based on their estimated fluid needs. [s. 71. (4)]

(110)

2. Resident #005 was offered 125ml of juice and not the planned menu at lunch. An amount of 250ml of fluids was not offered to resident #005.

A review of the resident's total daily fluid intake, for the day observed, revealed a 465ml shortfall in fluids consumed based on a range of their estimated fluid needs. [s. 71. (4)]

(110)

3. Resident #006 was observed and offered 125ml of juice and a mug of coffee or tea at lunch. A review of the dietary kardex and menu with a dietary aide confirmed that resident #006 should have received 125ml apple juice, 125ml milk, 125ml water plus coffee/tea. These missing fluids represented a shortfall of 250mls being offered to resident #006 at lunch.

A review of the resident's total daily fluid intake, for the day observed, revealed a 200ml - 465mls shortfall in fluids consumed based on a range of their estimated fluid needs. [s. 71. (4)]
(110)

4. Resident #011 was also monitored at lunch and offered 125ml of juice.

A review of the resident's plan of care directed staff to provide a preferred fluid at meals. The dietary aide confirmed that resident #011 should have received 125ml milk, 125ml water plus 125ml of their preferred fluid. These missing fluids represented a shortfall of 375mls being offered to resident #011 at lunch.

A review of the resident's total daily fluid intake, for the day observed, revealed a 875ml -1160mls shortfall in fluids consumed based on a range of their estimated fluid needs. [s. 71. (4)]

The planned menu for beverages/ fluids was not offered to residents #004,

#005, #006, #011 and may have contributed to the residents not consuming their estimated fluid needs for the day.

Sources: 'Policy No: LTC-CA-WQ-300-05-08 Menu Fluid Guidelines', Resident #004, #005, #006 and #011's plan of care, mealtime observations, dietary kardex, staff interviews including PSWs #101, #105, #111, Dietary Aide #109, AFSM #106 and the RD. [s. 71. (4)]

An Order was made by taking the following factors into account:

Severity: There was potential for actual harm to residents #004, #005, #006, #011, when fluids were not provided as planned. An inadequate fluid intake can lead to negative outcomes for a resident including dehydration.

Scope: The scope of this non-compliance was widespread as at least three out of three residents reviewed were impacted.

Compliance History: The licensee has one or more unrelated non-compliance in the last 36 months.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DIANE BROWN

Service Area Office /
Bureau régional de services : Toronto Service Area Office